State of West Virginia
Public Employees Insurance Agency
Retired Employee's Optional and Dependent Life Insurance Enrollment Form

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Complete this form to enroll for, continue or increase life insurance coverages. Complete all sections of the form except the last section titled ''AGENCY''.

RETIREE

Name (Last)	(First)	(MI)	(Generation)	Social Security Number

Gender (Mark One) ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Work Phone ( )

Street Address	City	State	Zip Code	Home Phone ( )

Optional Life Insurance -- If you have enrolled in basic life insurance, you may choose to enroll for optional life insurance for yourself. If you choose a plan higher than what you have as an active employee, you must complete and attach a Evidence of Insurability Form, and be approved by the life insurance carrier. To enroll for coverage, check the box beside the amount of life insurance you desire:

Retiree's Age	☐ Plan I	☐ Plan II	☐ Plan III	☐ Plan IV	☐ Plan V
Under age 65	$ 5,000	$ 10,000	$ 15,000	$ 20,000	$ 30,000
Age 65 to 69	3,250	6,500	9,750	13,000	19,500
Age 70 and above	2,500	5,000	7,500	10,000	15,000

Retiree's Age	☐ Plan VI	☐ Plan VII	☐ Plan VII	☐ Plan IX	☐ Plan X
Under age 65	$ 40,000	$ 50,000	$ 75,000	$100,000	$150,000
Age 65 to 69	26,000	32,500	48,750	65,000	97,500
Age 70 and above	20,000	25,000	37,500	50,000	75,000

Please designate the beneficiary(s) of your optional life insurance coverage below. You may change your beneficiary at any time by filing a Change of Beneficiary form with PEIA. The name of the beneficiary should be fully spelled out, and written "Jane B. Doe," not "Mrs. John Doe" or "Mrs. J. A. Doe".

Beneficiary Name (Last, First, MI, Generation)	Address (Street Address, City, State, Zip Code)	Social Security Number	Relationship to the Insured	Distribution %
1)				
2)				
3)				
4)				

If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary after his/her name above. If no percentage is noted, the death benefit will be paid in equal shares to the named beneficiaries who survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

Dependent Life Insurance -- You may choose to enroll for dependent life insurance for your spouse and/or children. If you choose a plan higher than what you have as an active employee, you must complete and attach a Evidence of Insurability Form, and be approved by the life insurance carrier. To enroll, check the box beside the amount of dependent life insurance you desire. The beneficiary of the dependent life insurance policy is the employee.

To enroll for dependent life insurance, mark the plan of your choice and complete the following information:

☐ Plan I -- $ 5,000 for your spouse and $ 2,000 for each child

☐ Plan II -- $10,000 for your spouse and $ 4,000 for each child

☐ Plan III -- $ 15,000 for your spouse and $ 7,000 for each child

☐ Plan IV -- $ 20,000 for your spouse and $ 10,000 for each child

Dependent Name (Last, First, Middle Initial)	Social Security Number	Date of Birth (mm/dd/yyyy)	Relationship to the Insured	Date Eligible* (mm/dd/yyyy)
			Wife Husband	
			Daughter Son	
			Daughter Son	
			Daughter Son	
			Daughter Son	
			Other specify below**	

*Date of Marriage or Adoption, if applicable. To add a dependent to your health coverage, you must complete a Change-In-Status form.
* *Must be eligible dependent according to PEIA rules. See your PEIA Summary Plan Description for details.

Specify relationship:

Selection, Acceptance and Deduction Authority - I am enrolling for (Mark all that apply):

☐ Optional Life Insurance ☐ Dependent Life Insurance (spouse and/or child)

You must mark ONE of the following statements:

☐ The benefits have been explained to me, and I decline to participate.

☐ The benefits have been explained to me, and I hereby accept the forms of group coverage indicated above, and authorize deduction of my premium contribution from my earnings until revoked by me in writing. I understand that the PEIA may change the types or levels of benefits or the amount of contribution.

AFFIDAVIT

Tobacco Affidavit

Please mark which members of the family use tobacco and sign the acceptance box below. If the policyholder is tobacco-free, you will receive a discount on the optional life insurance premium. I acknowledge by signing the acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status.

Who uses tobacco: ☐ Policyholder ☐ Dependent (spouse and/or children) ☐ No Tobacco Users within the last six (6) months

ACCEPTANCE

I hereby accept the basic life insurance. I understand that the PEIA may change the types or levels of benefits or the amount of contribution. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that those who provide false information may be prosecuted.

Employee Signature: Date:

AGENCY

To Be Completed By The Employer:

Agency Name	Account Number

OPT Plan	Dep Plan	Date of Retirement	Effective Date of Coverage

I hereby certify that the information above is true to the best of my knowledge, and that the employee is eligible for coverage under PEIA.

Authorized Signature: Date:

WHITE--PEIA **PINK--Payroll Location** **GOLD--Enrollee** Revised September, 2006